Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N069001	A. BUILDING: _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS The following citations represent the findings of a Non-Compliance Revisit.	{S 000}		
{S 600} SS=C	28-39-158(a) DIETARY SERVICES Dietary services. The nursing facility shall provide each resident with nourishing, palatable, attractive, non-contaminated foods that meet the daily nutritional and special dietary needs of each resident. A facility that has a contract with an outside food management company shall be found to be in compliance with this regulation if the company meets the requirements of these regulations. (a) Staffing. (1) Overall supervisory responsibility for the dietetic services shall be the assigned responsibility of a full-time employee who is a licensed dietitian or a dietetic services supervisor who receives regularly scheduled onsite supervision from a licensed dietitian. The nursing facility shall provide sufficient support staff to assure adequate time for planning and supervision. (2) The nursing facility shall implement written policies and procedures for all functions of the dietetic services department. The policies and procedures shall be available for use in the department. Note: The dietetic services supervisor shall meet the requirements as stated in K.A.R. 28-39-144(r) (1) through (4)	{S 600}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N069001	A. BUILDING: _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 600}	Continued From page 1 This REQUIREMENT is not met as evidenced by: The facility had a census of 64 residents. The sample included 4 residents. Based on observation, record review and interview, the facility failed to employ a certified dietary manager for the 64 residents who reside in the facility. Findings included: - On 12/9/14 at 9:50 AM, observation revealed Dietary Staff A , in the kitchen, overseeing the preparation of the noon meal. On 12/9/14 at 10:00 AM, Dietary Staff A stated he/she was not a certified dietary manager. On 12/9/14 at 11:00 AM, Administrative Staff B verified Dietary Staff A was not certified, and verified the facility does not have a certified dietary manager. The facility failed to employee a certified dietary manager for the 64 residents who reside in the facility.	{S 600}		